DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03 - 004

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
Julyl 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.90

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ No Budget Impact
b. FFY 2004 $ " " "

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, p. 4a-1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, p. 4a-1

10. SUBJECT OF AMENDMENT:
TECHNICAL AMENDMENT TO CORRECT PROGRAM COVERAGE

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark Trail

13. TYPED NAME: MARK TRAIL

14. TITLE: CHIEF, MEDICAL ASSISTANCE PLANS

15. DATE SUBMITTED:
June 10, 2003

16. RETURN TO:
Department of Community Health
Medical Assistance Plans
2 Peachtree Street, NW
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 16, 2003

18. DATE APPROVED:
July 11, 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Mark L. Webster for Rhonda Cottrell

21. TYPED NAME:
Rhonda R. Cottrell

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

DIALYSIS CLINICS

Dialysis services include those services and procedures designed to promote and maintain the functioning of the kidney and related organs.

Limitations

Hemodialysis or peritoneal dialysis services are limited to recipients wh0 have a diagnosis of chronic renal failure [End Stage Renal Disease (ESRD)]. Reimbursement will be made to any Medicare Certified Dialysis Facility (Hospital or Freestanding) enrolled in the Medicaid Dialysis Program. Providers will be reimbursed for the physician or facility services rendered in an inpatient or outpatient hospital or in a freestanding dialysis clinic setting. Coverage of ESRD recipients is limited to:

1. Services rendered by providers enrolled in the dialysis program:
2. Recipients enrolled in the program:
3. Recipients not eligible for Medicare, and
4. Services provided during the ninety-day (90) waiting period required for Medicare eligibility determination.

Non-Covered Services

Non-covered services in the program include:

1. Services provided for acute renal failure:
2. Services not listed as separately billable in the policy manual:
3. Experimental services or procedures, or those that are not recognized by the profession, the Department or the United States Public Health Service as universally accepted treatment, and
4. Services provided to recipients not enrolled in the program.